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The Effects of Population Disbursement, Percentage of Medicare Beneficiaries, and Per Capita Income on Medicare Fee Schedule Prices

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ABSTRACT

This thesis is an overview of the existing pay disparity in the fee-for-service billing amounts for professional medical services provided by physicians to Medicare patients in the United States. Will improvements in the per capita income, change in percentage of Medicare participants, or change in the population disbursement result in higher Medicare fee-for-service billing amounts for healthcare providers?

Mississippi has one of the fewest primary care physicians per capita rates than any other state. One reason may be the Medicare fee-for-service prices paid to physicians. This paper will show Mississippi Medicare fee-for-service fee schedule prices for a sample of HCPCS codes compared to the Medicare rates for several other states as a percentage of the Mississippi reimbursement rate. Similarly, the per capita income of these states is compared to the per capita income of Mississippi to determine a percentage of Mississippi per capita income to the comparison state. The percentage of Medicare participants, percentage of urban population, percentage of rural population, and percentage of very rural population is similarly scaled. Each factor was then compared to the percentage of Medicare fee-for-service reimbursement amount to determine what correlation exists between these factors. Per capita income and percentage of population benefitting from Medicare may be contributing factors for the Medicare physician fee-for-service rates, because they appeared to have a relationship with the Medicare physician fee-for-service billing rates studied.

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LIST OF ABBREVIATIONS

AALL	American Association of Labor Legislation
AMA	American Medical Association
CPT	Current Procedural Terminology
EPA	Environmental Protection Agency
ESRD	End Stage Renal Disease
FFS	Fee-for-service
GPCI	Geographical Price Cost Index
HCPCS	Healthcare Common Procedure Coding System
HPSA	Health Professional Shortage Area
HSIP	HPSA Surgical Incentive Payment
HI	Hospital Insurance
MPFS	Medicare physician fee schedule
MP RVU	Malpractice Relative Value Unit
PCP	Primary care physician
PE RVU	Practice Expense Relative value unit
PFS	Physician fee schedule
SMI	Supplementary Medical Insurance

INTRODUCTION

History of Insurance

Simply put, health insurance is a written statement that defines the terms of an agreement between an individual policyholder and an insurance company. The individual policyholder makes payments to the health plan provider, the payer, and, in exchange, the insurance company provides benefits, in the form of payments for medical services.

Americans began thinking about health insurance in 1910 when the American Association of Labor Legislation (AALL) argued that the American workforce's health was in danger while in the industrial workplace. In 1932 during the Great Depression, the Committee on the Costs of Medical Care was established to explore the trends surrounding healthcare spending in the United States. At that time, the committee determined that it was impractical for the American public to provide the money for their individual healthcare needs. As a result of this committee, Blue Cross hospital insurance began in 1932 and provided health insurance for hospital care only. Then, in 1939, Blue Shield insurance plans, which covered all physician services, surfaced in the healthcare market.

During the 1940s, the American trade unions demanded that their employers provide health benefits as part of their compensation package, and, therefore, the voluntary health insurance sector saw substantial growth. In 1950, the United States Congress proposed and passed a piece of legislation that provided medical care coverage for public assistance recipients; these Federal payments were included in the States'

payments to the medical providers. Then, in 1960, Congress passed the "Medical Assistance to the Aged" piece of legislation that provided support to elderly people who needed further assistance with overbearing medical expenses.[i]

In July of 1965, under the guidance of President Johnson, Congress issued Title XVIII and Title XIX of the Social Security Act, which established the national Medicare and Medicaid Programs, respectively. In addition, the newly established Medical Care Association created the standards for Medicare law, which was geared toward the elderly. Surprisingly, physicians grew to appreciate the passing of Medicare, amounts because the government promised to reimburse them for their professional services "according to their customary fees."[ii] Several other attempts were made by late Presidents to alter the Medicare and Medicaid plans, however, both are still in place today.

An Overview of Medicare and Medicaid

Medicare is a type of government provided health insurance for people age 65 or older, people with disabilities under the age of 65, and people with End-Stage Renal Disease (ESRD)[iii]. Originally, Medicare was established to provide assistance for the medical needs of the elderly, however, in 1973, the disabled and people with ESRD[iv], a chronic kidney disease that requires permanent use of dialysis or a kidney transplant, were included in the program.[v] On July 1, 1966, when Medicare officially started, approximately 19 million people nationwide enrolled in the service.[vi]

Medicaid is a voluntary federal and state program designed to assist states with long-term healthcare costs associated with the poor and provides health insurance coverage for poor and disabled individuals. Enacted in the state of Mississippi in 1969,

Medicaid is now available in all 50 states and also in the five inhabited United States territories. This program differs from Medicare because it only pays for medical services and each state must contribute money to provide Medicaid to its eligible and enrolled citizens. Medicaid is paid to healthcare providers rather than its beneficiaries. Then, the federal government matches the contribution to determine the total Medicaid pool.

To qualify for Mississippi Medicaid, an individual must:[vii]

- Be a citizen of the Unites States or an alien lawfully admitted for permanent residence,
- Have limited finances including income and resources (several specific limits apply based on individual status),
- Be a resident of the state,
- Be age 65 or older, blind, qualified disabled under the Social Security Administration definition age 18 or older, widowed age 50-65 who do not receive Medicare, or a patient or spouse of patient in a Medicaid accepting long-term care medical facility,
- File an application through the Medicaid Regional Office, and
- Provide requested verification within allowed time restrictions.

Components of Medicare

There are four sections of Medicare: Parts A, B, C, and D.

Medicare Part A, also referred to as Hospital Insurance, covers a variety of medical services and associated items including inpatient hospital care, limited skilled

nurse care, home health care services, hospice care, and inpatient medical care in a "religious nonmedical health care institution."[viii] These are described below:

- Inpatient hospital care services are any medical or nonmedical services provided after a physician has formally admitted a patient into a Medicare certified healthcare facility. The services include "semi-private rooms, meals, general nursing, and drugs."[ix]
- Certified healthcare facilities are "acute care hospitals, critical access hospitals inpatient rehabilitation facilities, and long-term care hospitals, qualifying clinical research"[x] facilities, and mental health care institutes.
- Limited skilled nursing facility care "semi-private rooms, meals, skilled nursing and rehabilitative services, and other medically necessary services or supplies after a minimum three day medically necessary inpatient hospital stay.[xi]
- Home health services are those that are ordered by a physician and provided by a "Medicare-certified home health agency."[xii] These services include a variety of medically necessary acute or short-term skilled nursing care, physical therapy, speech language pathology services, occupational therapy for people with a continuing need, medical social services, part-time home health aide services, and house use medical supplies.[xiii]
- Hospice care is for people who are certified as terminally ill by both a hospice doctor and the patient's primary physician. This determination places a life expectancy of six months or less on the person, and Medicare

allows coverage of certain approved services in the person's home or another living facility; the services include "medical, nursing, and social services, drugs, some medical equipment, all items and services need for pain relief and symptom management, and other services like spiritual and grief counseling."[xiv]

- Religious non-medical health care institution provided inpatient care coverage is limited to inpatient, non-religious, and non-medical services that do not require a physician's order; for example: room and board, a walker, or unmedicated wound dressings.[xv]

Medicare Part B, medical insurance, provides coverage for medically necessary physician and health care provider services, outpatient care, medical equipment, several preventive services, and home health care services.[xvi]

Medicare Part C, the Medicare Advantage Plan, "provides private plan options, for example managed care, for Medicare beneficiaries who are enrolled in Parts A and B."[xvii] It is managed by Medicare-approved private insurance companies and includes all benefits and services covered under Parts A and B, along with optional Medicare prescription drug coverage, and for an additional cost, may incorporate extra benefits and services.[xviii] There are six types of Medicare Advantage Plans available for Medicare patrons.

1. The Health Maintenance Organization (HMO) plans
2. Preferred Provider Organization (PPO) plans
3. Private Fee-for-Service (PFFS) plans
4. Special Needs Plans (SNPs)

5. HMO Point-of-Service (HMOPOS) plans

6. Medical Savings Account (MSA) plans

In 2004, the Medicare Prescription Drug, Improvement, and Modernization Act established Medicare Part D. Medicare Part D, also called Medicare prescription drug coverage, is operated by Medicare-approved private insurance companies and assists in the coverage of outpatient prescription drug costs or helps lower the costs of prescriptions drugs.

Medicare Financing

Medicare is an entitlement program, which means that it is required to pay for covered services provided to enrollees so long as specific established criteria are met. In general, Medicare is accounted for through two government maintained trust funds: the Hospital Insurance (HI) Trust Fund for Medicare Part A and Supplementary Medical Insurance (SMI) Trust Fund for Medicare Parts B and D. Medicare Part C is financed by payments made from the HI and SMI funds.

Medicare Part A – Hospital Insurance is designed to be a self-supporting program, in which the program is almost entirely funded by designated revenue sources, rather than General Fund tax revenue. Approximately 86 percent of Medicare Part A revenue is financed by a mandatory payroll tax of 2.90 percent on wages earned for all workers in the United States. This tax is shared equally by employees and employers. Each wage earner's paycheck has 1.45 percent of the gross earnings deducted from the check, and

the employer must match the amount deducted. Additionally, each self-employed worker pays a 2.90 percent tax on all self-employment income.[xix]

Part A funding is also raised by a 0.9 percent tax on the income for high-income beneficiaries, individuals with more than $200,000 and couples with more than $250,000, making their total taxed rate 2.35 percent in 2013.[xx] The remaining financing for Part A stems from premiums from certain beneficiaries who are not eligible but choose to voluntarily enroll in Medicare Part A (1 percent), reimbursements from the United States Treasury General Fund for the cost of providing Part A coverage to aged people who retired when Part A began, and interest earnings on assets "invested in interest bearing obligation's of the United States Government"[xxi] through the (HI) Trust Fund making up 6 percent.[xxii]

The supplemental components of Medicare, Parts B and D, are not self-sufficient and require contributions from the United States General Fund revenue. Medicare Part B is primarily financed through the monthly beneficiary premium payments from Medicare Part B enrollees and automatic withholdings from individuals with Social Security benefits (25 percent)[xxiii] and contributions from the Treasury Department's General Fund (72 percent).[xxiv] Beginning in 2007, higher income Medicare Part B enrollees paid a higher premium than other individuals. Part D is also funded primarily through state payments for dually eligible Medicare and Medicaid individuals (3 percent),[xxv] beneficiary premiums (13 percent),[xxvi] and the General Fund of the Treasury Department (74 percent).[xxvii]

Eligible Participants

Medicare Part A provides free Medicare Hospital Insurance and is available for most American citizens or permanent residents age 65 or older who meet the following criteria:

- the individual or his or her spouse receives or is eligible to receive Social Security benefits or railroad retirement benefits,
- the individual or his or her spouse (living, deceased, or divorced) worked as a government employee for at least 40 quarters as a Medicare-covered employee,[xxviii] or
- the individual is the dependent parent of a fully insured deceased child.

If an individual does not meet these requirements, he or she can pay a monthly premium to purchase Medicare Hospital Insurance. Individuals under the age of 65 are eligible for free Medicare Part A coverage if any of the following criteria are met:

- the individual is entitled to receive Social Security disability benefits for 24 months,
- the individual receives a disability pension from the railroad retirement board and meets certain requirements for a permanent disability,
- the individual has Lou Gehrig's disease and receives Social Security benefits,
- if the individual, his or her parents, or his or her deceased spouse held a government job and worked for at least 40 quarters as a Medicare-covered employee where they became eligible for Social Security disability benefits for 24 months,

- the individual has permanent kidney disease and must receive dialysis or a transplant, is eligible to receive monthly benefits under Social Security or the railroad retirement system, has worked in a government job and meet the conditions to receive Medicare because their taxes have been paid, or he or she is the child or spouse of an individual who qualifies for Social Security or Medicare benefits because they held a long-term government job,[xxix] or
- the individual has one or more specified lung diseases or types of cancer and lived for six months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009.[xxx]

Any individual who qualifies for free Medicare Part A Hospital Insurance can pay a monthly premium and enroll in Medicare Part B (Medical Insurance.) The monthly payment amount is dependent on an individual's income. If an individual is not eligible for free Medicare Part A insurance but is age 65 or older and is a United States citizen or a lawfully admitted noncitizen living in the United States for a minimum of five years, he or she can purchase the Medical Insurance component.

Individuals who receive Medicare Hospital and Medical Insurance can join a Medicare Part C Medicare Advantage Plan. These programs are typically offered by private companies and approved by Medicare. It is also common for individuals to pay a monthly premium for the services offered by a Medicare Advantage Plan because it offers significant benefits outside of Medicare Parts A and B.

Anyone who receives Medicare Part A, Part B, or Part C is eligible for Medicare Part D (Prescription Drug Coverage) as well. Because this program is voluntary, individuals must pay a monthly premium for this coverage, and this payment is also dependent on the patient's income.

The Medical Billing Process for Medicare

Physicians are compensated for their professional services in a number of ways. Medicare pays physicians on a fee-for-service basis. The fee-for-service system begins with the physician providing services for the patient. Medicare reimburses the provider for the services on behalf of the patient after the medical claim is filed.

Essentially, Medicare's fee-for-service billing system is an "a-la-carte style"[xxxi] of medical care billing because each professional service performed is separately billed to the patient by the physician. Under this billing method, physicians are paid for their professional services provided in clinical offices, hospitals, and other qualifying healthcare facilities. The individual price for each service is based upon a Medicare fee schedule.

The fee-for-service billing method has a reputation for rewarding physicians. By the very name "fee-for-service" the goal of the method is to bill Medicare for each individual service provided. Therefore, the more services a physician provides, "the more they get paid, regardless of the outcome."[xxxii] Physicians can bill a patient for a plethora of codes including generic hospital, lead surgeon, anesthesiologist, and post-op charges all for one surgery.

Alternatively, Medicare pays a hospital on a per admission basis; therefore, the hospital's incentive is to reduce hospital stay and reduce the number of services provided during the stay. Oftentimes, physicians have no incentive to mirror the hospitals target to reduce the length of hospital stay or reduce the services provided, because they are paid on a fee-for-service basis and are typically not employees of the hospitals in which they see patients. Physicians order tests, x-rays, lab work, etc. to increase their revenue with the fee-for-service billing method.

Medicare Physician Fee Schedule

"A fee schedule is a complete listing of fee maximums used by Medicare to pay physicians, health care professionals, or providers and suppliers on a fee-for-service basis."[xxxiii] The amount of the Medicare payment for a patient's particular medical care is the lower of the actual charge or the Medicare Physician Fee Schedule (MPFS).[xxxiv] The pricing information provided in the fee schedule provides the maximum fee schedule amount for each service according to its Healthcare Common Procedure Coding System (HCPCS) code. The health insurance claims are coded to ensure that they are processed accurately and efficiently. There are over 10,000 codes in the current fee schedule. The HCPCS is the primary system used in the United States and is divided into two sections: level one and level two. The American Medical Association (AMA) sponsored level one coding section is composed of the Current Procedural Terminology (CPT); this includes medical procedures and services rendered by physicians and other health professionals. Level two details products, supplies, and services not noted in the CPT including

ambulance services, prosthetics, orthotics, and other non-professional services and procedures.

Physicians are paid at 100 percent of the fee. Nurse practitioners, physician assistants, registered dieticians, nutrition professionals, medical nutrition therapy services, and clinical nurse specialists are typically paid 85 percent of the fee schedule amount and social workers receive 75 percent.[xxxv] Nonparticipating healthcare professional and healthcare suppliers receive an automatic 5 percent reduction in the approved amount for the professional services because they did not register with the "Medicare Participating Physician or Supplier Agreement." This contract states that the healthcare professionals and suppliers agree to charge no more than the Medicare approved amounts. By not signing this document, the nonparticipating institutions submit Medicare claims on a case-by-case basis and are limited by the limiting charge as to the amount that they can charge the beneficiary for the services or procedures performed. Physicians can also receive additional payments for their services if they meet certain requirements for things including Health Professional Shortage Area (HPSA), HPSA Surgical Incentive Payment (HSIP), Electronic Health Records Incentive Program, and Physician Quality Reporting System.

The payment policy indicators on the fee schedule provide information about the payment policy including global surgery days, multiple procedure adjustments, bilateral procedure adjustments, surgery assistants, team of surgeons, and co-surgeon involvement, required physician supervision, and applicability of professional and technical components. The pricing for each HCPCS code is determined based on the three relative value units (RVU) components. Work RVU reflects the relative time and

intensity associated with providing a service, typically half of the overall total amount. Practice expense RVU (PE RVU) reflects the costs of renting office space, purchasing supplies and equipment, and hiring staff. Lastly, malpractice RVU (MP RVU) reflects the relative costs of purchasing malpractice insurance.

A Geographical Price Cost Index (GPCI) is assigned by locality description depending on the area of the country where the service took place. Localities are also noted by codes. Some states may have more than one locality if there is a significant metropolitan area in the state. The GPCI is applied to each component of the fee schedule and adjusts all three components of the RVUs by the GPCI for the specific location in which the service is provided compared to the national average costs for the expenses detailed in the components of the relative value unit. There is a separate GPCI for physician work, practice expense, and malpractice liability costs.

A conversion factor is also applied to the calculation. This factor, which is determined from the Medicare Economic Index and the actual expenditures relationship with the target Sustainable Growth Rate, is updated annually. 2012 conversion factor is $34.0376.[xxxvi]

The fee-for-service non-facility price is calculated:[xxxvii]

[(Work RVU * Work GPCI) + (Transitioned Non-facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Year Conversion Factor

The fee-for-service facility price is calculated:

[(Work RVU * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Year Conversion Factor

The fee schedule also displays a facility price and a non-facility price. Typically, physicians who perform services in non-facilities, their clinical offices, will receive higher payments because they personally had to supply the medical and administrative staff, supplies, equipment, utilities, etc. in order to perform the medical procedures. Alternatively, those physicians who performed the same services in a medical facility, a hospital or ambulatory surgical center, will typically receive a lower payment for the same professional services.

The limiting charge is the highest amount that can be charged for the professional services provided. Specifically, the non-facility limiting charge is the maximum amount a beneficiary can be charged for the medical service received by a nonparticipating healthcare professional, by a healthcare professional who does not accept assignment, and by a healthcare professional in an office or other non-facility environment. The facility limiting charge is the maximum amount a beneficiary can be charged for services provided by nonparticipating healthcare professionals, by healthcare professional who do not accept assignment, and by healthcare professionals performing the service in a facility setting.

The Importance of Primary Care Physicians

A primary care physician is "a physician who has a primary specialty in family medicine, internal medicine, geriatric medicine, or pediatric medicine."[xxxviii] Currently, three out of ten physicians in the United States are primary care physicians. This number has decreased over time because of the rise in popularity and range of medical specialization services provided by specialist physicians.[xxxix] In this report, the term physician includes both primary care physicians and specialists, because any physician can perform the professional services or procedures discussed in this paper.

RESEARCH

Mississippi has one of the lowest numbers of primary care physicians per capita than any other state in the country. This means that there is potentially a greater number of patients for each primary care physician in the state to serve. This study does not take into account a relative distribution of physicians in areas based on population but, rather, serves as an average number of how many patients each physician would have to see, in order for each patient to be seen by a physician from their state. This is illustrated in Table 1.

As illustrated in Table 2, Mississippi physicians see a higher number of Medicare patients then physicians in all but one other state.

Mississippi also has one of the lowest Medicare reimbursement rates. Table 3 illustrates the Medicare fee-for-service billing amounts for healthcare facilities, obtained from the fee schedule, for a sample of HCPCS Codes. Table 4 illustrates the Medicare fee-for-service billing amounts for the same HCPCS Codes but for non-facility pricing.

For purposes of this study, only states with one locality code are included. The states with one carrier locality listed are grouped by the Medicare fee-for-service system as one designating area, covering the entire state. This means that physicians around the entire state are deemed to have similar medical environments. While physicians across the country use the same HCPCS code for the same professional services performed, they do not get reimbursed same rate for those services. In these states listed below, the physicians and healthcare professionals are identified by the same locality indicator and,

therefore, bill the same amount the same medical services. Table 5 shows the locality codes of the states being surveyed.

Table 5 – Locality Description

State	Carrier Localities
AL	1010200
CT	1310200
KY	1510200
MS	730200
TN	1030235
WY	360221

The next illustrations, Tables 6 and 7, show the rate by HCPCS code paid in Mississippi as a percentage of the HCPCS code rate in the comparison state for both Facility and Non-Facility pricing.

The Facility Rate factors were compared to the Non-Facility Rate factors to determine if there were any differences between the reimbursement types. There were a relatively small number of differences on a few HCPCS Codes, but those differences were miniscule as show in Table 8. Since the data shows that there is no significant difference between the Facility and Non-Facility Medicare Physician Fee Schedule Rates for the same HCPCS Codes, the remainder of the analysis will utilize the Facility Rate only.

There is a variation in the Rate Comparison Factor determined for each code by state. In order to evaluate this variation, the mean, median, mode and range of these factors by state were calculated. The mean statistic is used to determine the usual, mathematical average of the values studied. The median statistic determines the middle number in the list of total values. The mode determines the most frequently occurring

value in the dataset; a particular data set can have multiple modes. The range describes the data set studied by showing the highest and lowest values and the difference between them. Table 9 illustrates the calculations.

Table 9 - Mean, Median, Mode and Range of Factors

	MS	AL	TN	WY	CT	KY
Mean	1.00	1.02	1.00	0.91	0.86	1.00
Median	1.00	1.01	1.01	0.91	0.86	1.00
Mode	1.00	1.01	1.00	0.94	0.89	1.00
Range	1.00	0.99 to 1.05	0.97 to 1.03	0.86 to 0.95	0.77 to 0.91	0.99 to 1.00

For comparison purposes, the mode of each state factor is the most appropriate indicator and will be used, because it is the most common factor for reimbursement among HCPCS Codes for each state.

Blue Cross Blue Shield and Medicaid Prices

For comparison, the Blue Cross Blue Shield pricing rates are included in Table 10. Both non-facility and facility amounts were included in the Table 10; however, there are only a few differences between the percentage reimbursement for facility prices and percentage reimbursement for non-facility prices among the codes studied. So, to be consistent with the research above, the facility comparison will be the only one considered in this paper.

As seen in Table 10, the Blue Cross Blue Shield physician billing prices are significantly higher than those prices, for the same medical procedures with the same HCPCS codes, for physicians billing Medicare patients. The range of percent difference

is 2589 percent for HCPCS Code 32554, a heart procedure, to 106 percent for code 99218, an initial observation care charge.

For additional comparison purposes, the Mississippi Medicaid prices for the same codes were also collected and analyzed in Table 11. These prices were obtained from the Mississippi Division of Medicaid interactive physician fee schedule. The lowest published Medicaid prices were chosen to show the largest billing price differences between Medicare and Medicaid patients in Mississippi. Generally, the Medicaid prices are significantly lower than the Medicare prices. The percent difference range is 132.42 percent to 16.3. Codes 59400 and 59510 are not covered by Medicaid, probably because most individuals who qualify for Medicaid are not likely to receive these infant delivery medical services.

Population Disbursement

In this evaluation, population disbursement is measured in three ways: Rural, Very Rural and Urban. The United States Centers for Medicaid and Medicare publish quarterly reports of each zip codes population disbursement classification. The population disbursement for the states included in the evaluation is illustrated in Table 12.

Table 12 – Population Disbursement

State	% of State – Rural	% of State – Very Rural	% of State - Urban
Mississippi	54.16%	21.63%	24.21%
Alabama	29.27%	18.50%	52.23%
Tennessee	48.40%	1.60%	50.00%
Wyoming	0.51%	86.36%	13.13%
Connecticut	19.55%	0.00%	80.45%
Kentucky	70.36%	2.14%	27.50%

As seen in Table 12, Wyoming has the highest percentage of very rural areas. Kentucky and Mississippi have the highest percentage of rural population from the list above. On the other hand, Connecticut has the highest percentage of urban area, in this study, and zero percent of very rural area. Table 13 shows Mississippi values as a factor of the comparison state's values for each category.

Table 13 – Population Disbursement as a Factor of MS

State	Rural Factor Compared to MS	Very Rural Factor Compared to MS	Urban Factor Compared to MS
Mississippi	1.00	1.00	1.00
Alabama	1.85	1.17	0.46
Tennessee	1.12	13.52	0.48
Wyoming	106.20	0.25	1.84
Connecticut	2.77	2163.00	0.30
Kentucky	0.77	10.11	0.88

Per Capita Income

Per capita income is a measure of wealth per person. Table 14 shows the Per Capita Income for each state being surveyed. It also shows Mississippi's Per Capita Income as a percentage of the comparison state's Per Capita Income.

Table 14 – Per Capita Income Compared to MS

State	Per Capita Income	MS Per Capita Income as a Factor of Comparison State's Per Capita Income
Mississippi	$33,657	1.000
Alabama	$35,926	0.937
Connecticut	$59,687	0.564
Kentucky	$35,643	0.944
Tennessee	$38,752	0.869
Wyoming	$50,567	0.666

Percentage of Medicare Beneficiaries to Total Population of State

The percentage of the population on Medicare is shown for each state being surveyed in Table 15. It also shows Mississippi's Medicare population as a percentage of the comparison state's Medicare population.

Table 15 – Percentage of Medicare Beneficiaries Compared to MS

State	Medicare Beneficiaries	Population	Medicare Beneficiaries as a Percentage of Population	MS Medicare Population as a Factor of Comparison State's Medicare Population
Mississippi	516,809	2,984,926	17.31%	1.000
Alabama	881,686	4,822,023	18.28%	0.947
Connecticut	586,545	3,590,347	16.34%	1.059
Kentucky	793,271	4,380,415	18.11%	0.956
Tennessee	1,109,791	6,456,243	17.19%	1.007
Wyoming	84,076	576,412	14.59%	1.186

ANALYSIS OF DATA

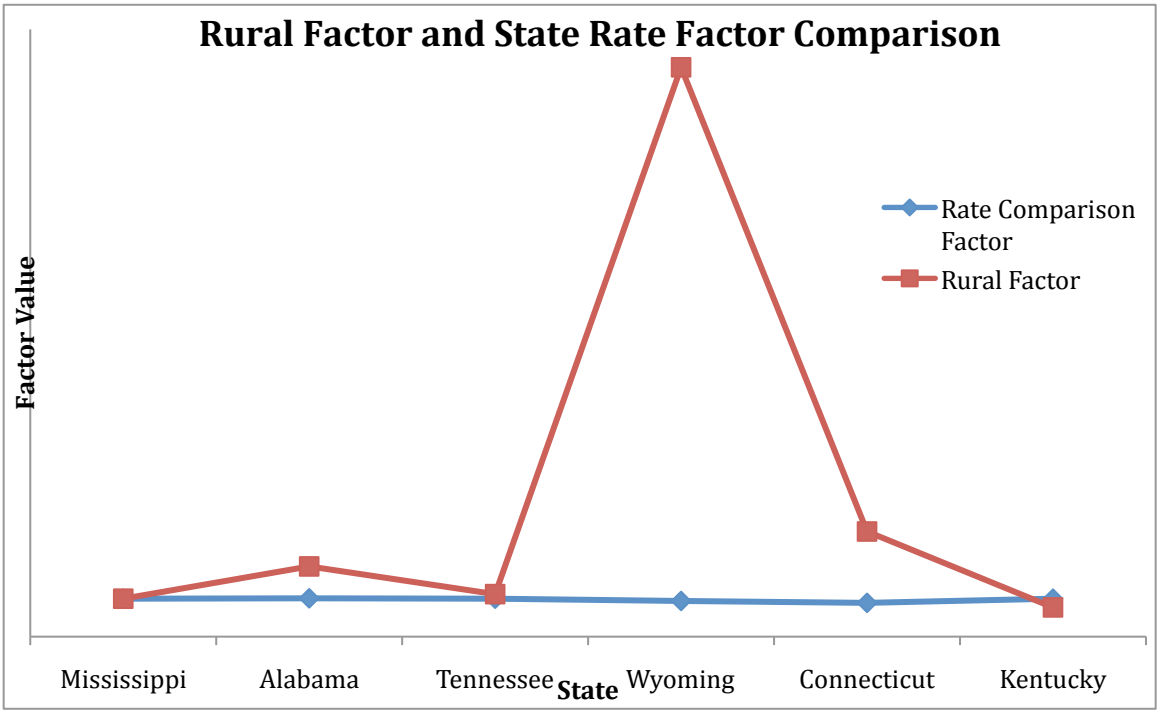

Figure 1. Rural Factor Compared to State's Rate Factor

The value for Wyoming is displayed as a relative value on Figure 1 because of its extremely high rate of 106.2. This graph shows that there is no correlation between the size of the rural population and the Medicare fee-for-service prices.

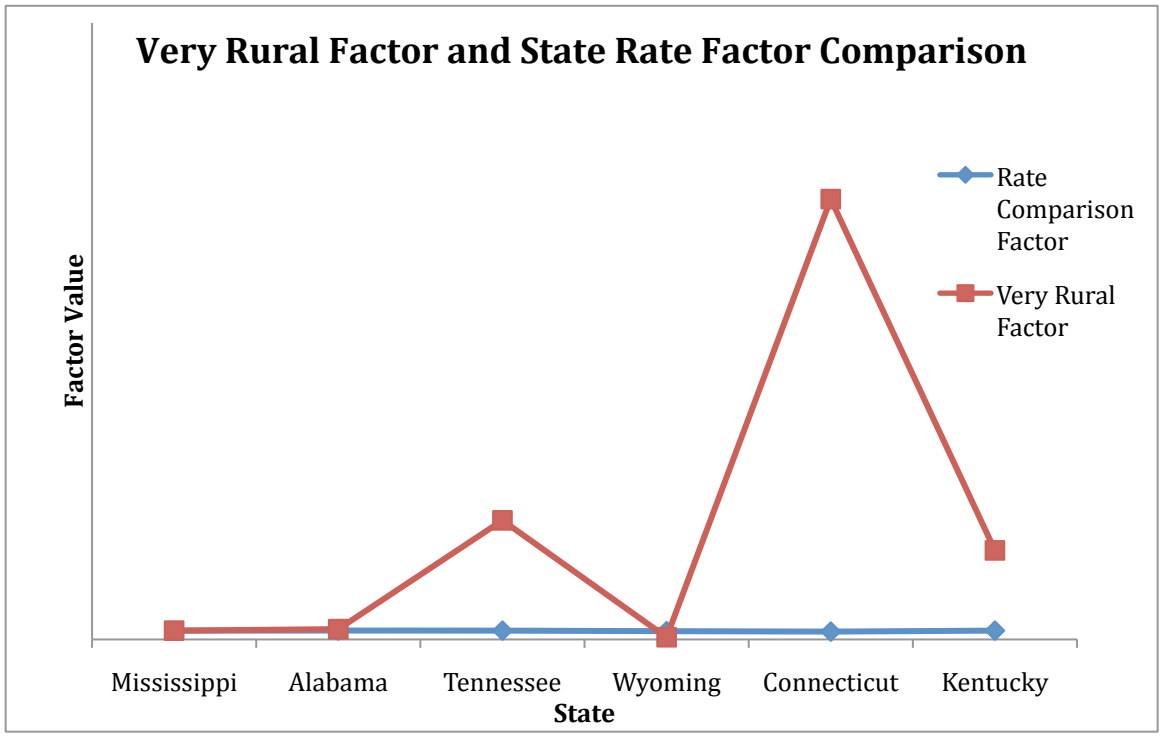

Figure 2. Very Rural Factor Compared to State's Rate Factor

The value for Connecticut was such an outlier at a rate of 2163 that it would not display in the graph area, so it is also shown as a relative value. This graph illustrates that there is no correlation between the size of the very rural population and the Medicare fee-for-service amounts.

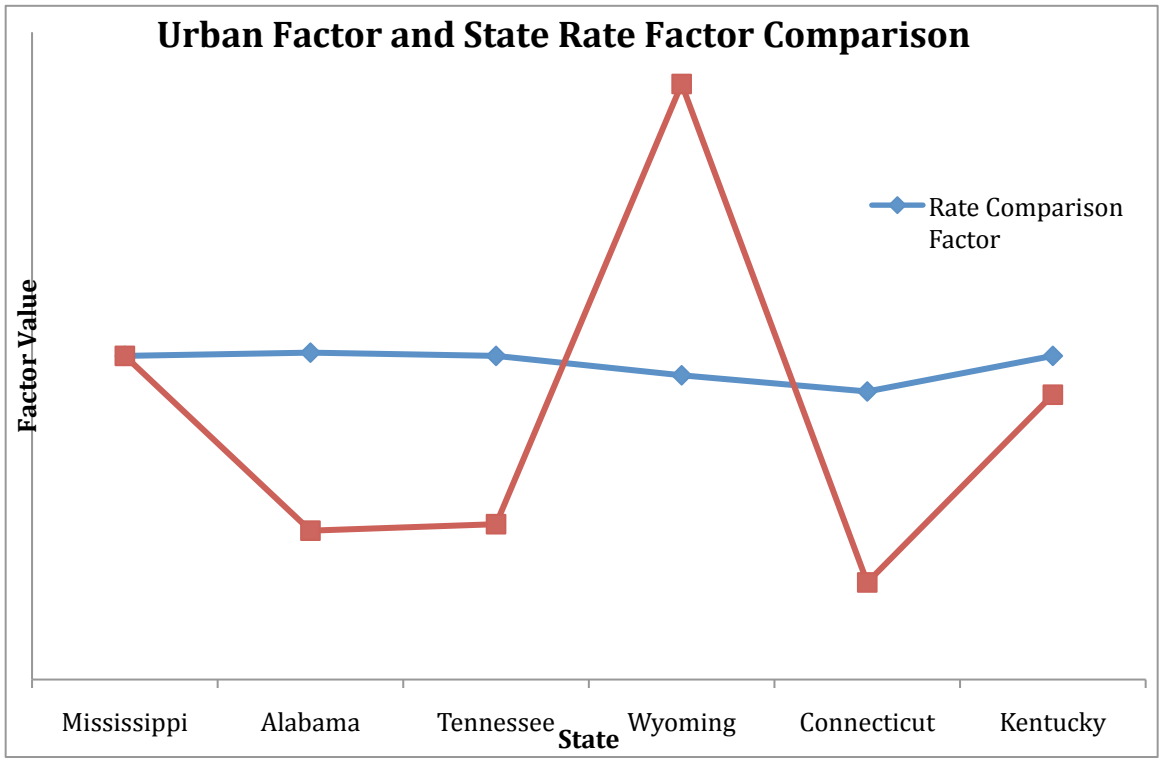

Figure 3. Urban Factor Compared to State's Rate Factor

This graph shows that there is very little correlation between the size of the urban population and the Medicare fee-for-service prices.

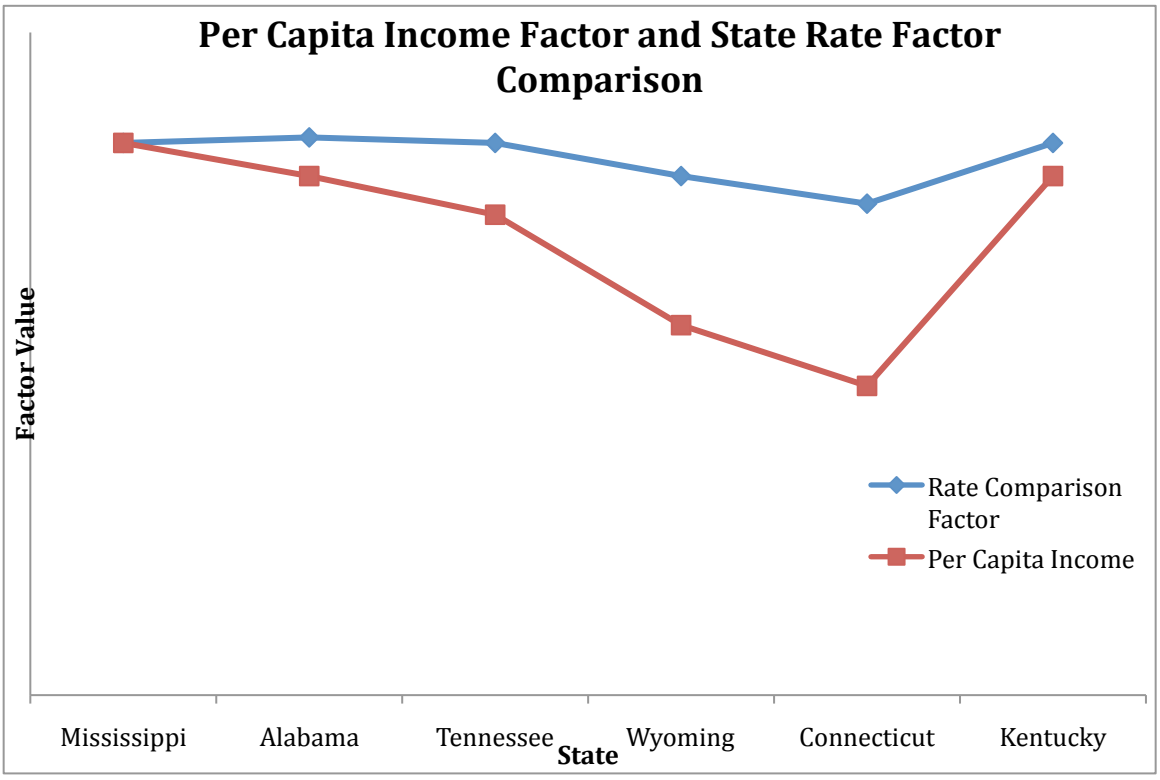

Figure 4. Per Capita Income Compared to State's Rate Factor

This graph illustrates the strongest correlation of all factors studied between the per capita income in each state and the Medicare fee-for-service prices.

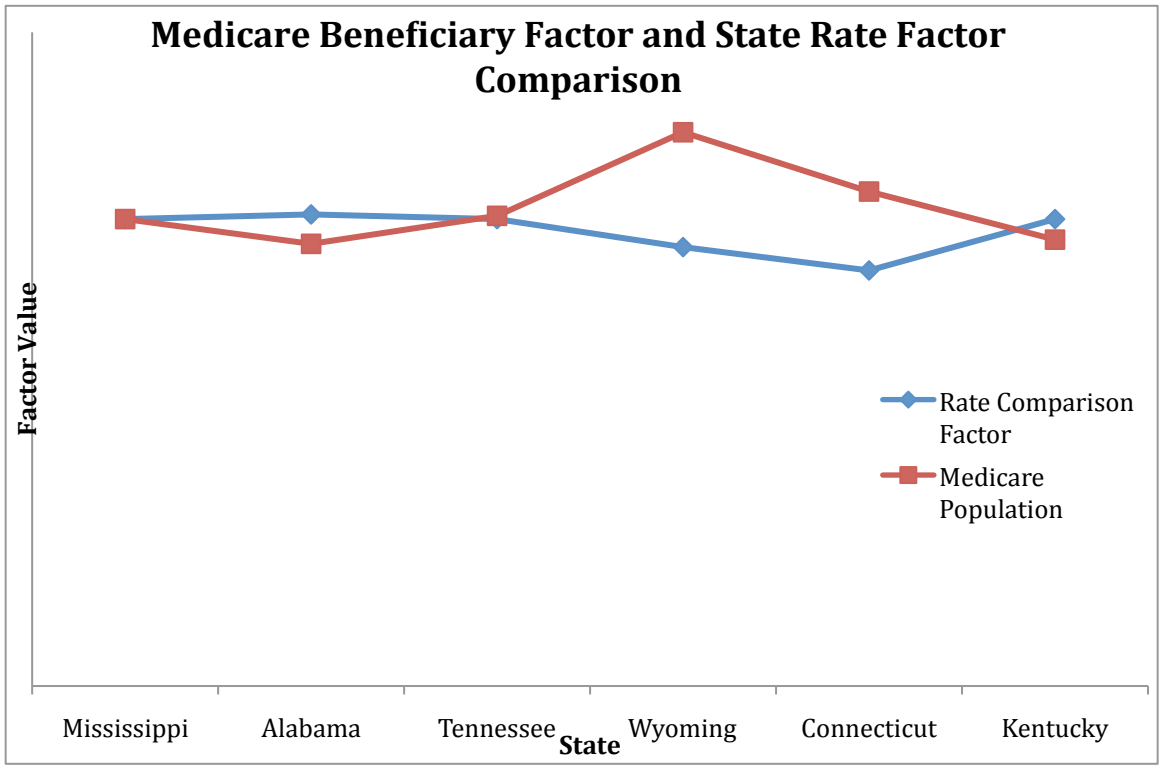

Figure 5. Medicare Population Compared to State's Rate Factor

This graph appears to show a slight indirect relationship between the percentage of the population benefitting from Medicare and the rate factor.

CONCLUSION

Based on the analysis of the data, the population density does not appear to be a strong factor in the Medicare physician fee-for-service billing rates, because they do not change proportionately based on their classifications of rural, very rural, or urban.

Per capita income may be a contributing factor for the Medicare physician fee-for-service rates, because there was a strong correlation between the individual states' 2012 per capita income and the Medicare physician fee-for-service billing rates studied.

The percentage of population benefitting from Medicare for each state had an indirect correlation to the Medicare physician fee-for-service billing amount. This may indicate that Medicare physician fee-for-service billing prices are lower for those states with a higher amount of Medicare patients.

Mississippi has one of the highest ratios of patients to PCPs as seen in Table 1 and Figure 6. In order to provide more accessible healthcare to Mississippians, the number of PCPs needs to be increased. Medicare fee-for-service billing prices are low in Mississippi compared to other and, therefore, may be a contributing factor in a primary care physician's decision to practice in Mississippi. Because the data shows that per capita income may be a contributing factor to the Medicare fee-for-service prices, Mississippi must look for ways to improve the state's wage earning potential among citizens. Ultimately, doing this may, in turn, facilitate higher Mississippi Medicare fee-for-service billing prices and attract more primary care physicians to the state.

APPENDIX

Table 1 – Primary Care Physicians Per Capita

State	Population	# of Primary Care Physicians	# of Patients Per Primary Care Physicians
Idaho	1,595,728	1,406	1,135
Utah	2,855,287	2,574	1,109
Nevada	2,758,931	2,564	1,076
Wyoming	576,412	543	1,062
Mississippi	2,984,926	2,859	1,044
Arkansas	2,949,131	2,892	1,020
Texas	26,059,203	25,845	1,008
Montana	1,005,141	1,010	995
Alabama	4,822,023	5,009	963
Oklahoma	3,814,820	4,045	943
Kentucky	4,380,415	4,689	934
Georgia	9,919,945	10,701	927
Indiana	6,537,334	7,098	921
South Carolina	4,723,723	5,187	911
Louisiana	4,601,893	5,080	906
Arizona	6,553,255	7,432	882
North Carolina	9,752,073	11,130	876
New Mexico	2,085,538	2,407	866
South Dakota	833,354	962	866
Kansas	2,885,905	3,354	860
Florida	19,317,568	22,741	849
Alaska	731,449	870	841
Tennessee	6,456,243	7,703	838
California	38,041,430	45,686	833
Iowa	3,074,186	3,696	832
Virginia	8,185,867	9,904	827
Colorado	5,187,582	6,312	822
Nebraska	1,855,525	2,294	809
Hawaii	1,392,313	1,730	805
North Dakota	699,628	874	800
West Virginia	1,855,413	2,329	797
Wisconsin	5,726,398	7,254	789
Oregon	3,899,353	5,068	769
Washington	6,897,012	9,077	760
Missouri	6,021,988	7,932	759
New Hampshire	1,320,718	1,754	753
New Jersey	8,864,590	12,037	736
Delaware	917,092	1,267	724
Minnesota	5,379,139	7,448	722
Illinois	12,875,255	17,854	721
Ohio	11,544,225	16,050	719
Michigan	9,883,360	14,968	660
Pennsylvania	12,763,536	19,464	656
Connecticut	3,590,347	5,514	651
New York	19,570,261	30,238	647
Maryland	5,884,563	9,093	647
Vermont	626,011	972	644
Maine	1,329,192	2,080	639
Rhode Island	1,050,292	1,991	528
Massachusetts	6,646,144	13,561	490
District of Columbia	632,323	2,582	245

Table 2 – Primary Care Physician Per Medicare Beneficiary

State	# of Medicare Beneficiaries	# of Primary Care Physicians	# of Medicare Patients Per Primary Care Physician
Arkansas	552,375	2,892	191
Mississippi	516,809	2,859	181
Alabama	881,686	5,009	176
Montana	177,835	1,010	176
Idaho	242,889	1,406	173
Kentucky	793,271	4,689	169
West Virginia	392,021	2,329	168
South Carolina	820,947	5,187	158
Oklahoma	625,924	4,045	155
Wyoming	84,076	543	155
Florida	3,527,830	22,741	155
Indiana	1,048,499	7,098	148
Nevada	379,860	2,564	148
South Dakota	141,079	962	147
Iowa	531,209	3,696	144
Tennessee	1,109,791	7,703	144
North Carolina	1,568,429	11,130	141
Louisiana	718,037	5,080	141
New Mexico	329,994	2,407	137
Kansas	448,215	3,354	134
Maine	276,467	2,080	133
Arizona	977,447	7,432	132
New Hampshire	231,444	1,754	132
Wisconsin	948,489	7,254	131
Missouri	1,040,491	7,932	131
Oregon	653,905	5,068	129
North Dakota	110,827	874	127
Hawaii	217,678	1,730	126
Nebraska	287,565	2,294	125
Delaware	157,289	1,267	124
Ohio	1,971,260	16,050	123
Georgia	1,318,733	10,701	123
Texas	3,187,332	25,845	123
Virginia	1,203,462	9,904	122
Pennsylvania	2,350,558	19,464	121
Vermont	117,393	972	121
Utah	299,427	2,574	116
New Jersey	1,378,274	12,037	115
Michigan	1,728,338	14,968	115
Washington	1,029,529	9,077	113
Minnesota	819,803	7,448	110
California	5,000,198	45,686	109
Illinois	1,907,859	17,854	107
Colorado	667,277	6,312	106
Connecticut	586,545	5,514	106
New York	3,093,591	30,238	102
Rhode Island	188,502	1,991	95
Maryland	827,426	9,093	91
Massachusetts	1,104,483	13,561	81
Alaska	69,301	870	80
District of Columbia	81,260	2,582	31

Table 3 - Medicare Facility Fee-for-Service Billing Amounts

Description	Code	MS	AL	TN	WY	CT	KY
Drainage of skin abscess	10060	89.69	89.15	90.39	98.60	105.33	89.92
Drainage of hematoma, seroma	10140	110.50	109.26	110.78	121.69	129.54	110.73
Complex drainage wound, postoperative infection	10180	166.40	162.77	165.31	185.83	197.36	166.69
Removal of breast lesion	19120	383.46	373.33	378.87	426.69	450.62	383.94
Masectomy, partial	19301	605.98	587.83	596.17	672.33	706.87	606.51
Removal of hip prosthesis	27090	771.40	753.40	764.47	856.82	906.45	772.51
Removal of hip prosthesis, complicated	27091	1,489.57	1,450.14	1,470.54	1,649.72	1,738.12	1,491.20
Hemiarthroplasty (partial hip replacement)	27125	1,054.72	1,028.29	1,043.08	1,169.85	1,234.94	1,056.05
Arthroplasty (revised kneecap with implant)	27438	782.48	764.13	775.35	869.05	919.26	783.60
Aspiration of plural space without imaging - Thoracentesis	32554	85.47	84.08	84.81	91.17	95.10	85.53
Aspiration of plural space with imaging - Thoracentesis	32555	106.76	104.84	105.77	114.10	118.96	106.82
Insert/replace permanent pacemaker	33208	488.34	471.54	477.98	540.88	565.98	488.56
Endoscopy ligate perf veins	37500	620.71	597.19	605.16	687.02	716.49	620.81
Remove tonsils and adenoids	42820	276.04	272.51	276.14	302.92	321.49	276.56
Esophagus endoscopy	43215	146.22	142.87	144.64	160.10	168.24	146.36
Colonoscopy, flexible	45378	205.64	200.78	203.26	225.15	236.43	205.84
Vaginal delivery	59400	1,977.03	1,898.55	1,928.52	2,221.62	2,331.17	1,978.04
Antepartum care (4 to 6 visits)	59425	339.29	323.40	328.14	379.54	394.92	339.22
Antepartum care (7 or more visits)	59426	598.47	571.03	579.30	668.60	695.80	598.36
Care after delivery	59430	132.62	126.51	128.34	148.21	154.24	132.59
Cesarean delivery	59510	2,184.87	2,095.59	2,128.90	2,457.65	2,577.56	2,185.86
Biopsy of thyroid with percutaneous needle	60100	74.31	72.98	73.64	79.52	82.98	74.36
Partial removal of thyroid, unilateral lobectomy	60220	665.77	650.08	658.74	733.26	772.36	666.54
Laparoscopy, with adrenalectomy, exploration of adrenal gland	60650	1,111.50	1,079.27	1,092.65	1,219.43	1,275.91	1,112.14
Injection, epidural blood or clot patch	62273	108.68	107.14	108.18	116.58	122.21	108.79
Drain outer ear canal lesion	69020	134.72	133.84	135.97	149.93	161.03	135.11
Contrast x-ray of brain	70010	58.85	56.88	57.54	64.35	66.94	58.86
X-ray exam of neck	70360	25.45	25.52	26.00	28.74	31.31	25.56
Mammogram screening	77057	73.73	73.91	75.12	82.05	88.80	73.99
Cytopathology	88141	29.21	29.11	29.49	31.88	34.02	29.28
Tissue exam by pathologist	88304	39.53	39.77	40.53	44.73	48.91	39.71
Tissue exam by pathologist, level 4 surgical pathology	88305	64.04	64.37	65.29	70.25	75.69	64.26
Histochemical stains, special stains	88314	72.10	72.69	74.02	81.13	88.65	72.42
Immunization administration	90471	23.13	23.27	23.68	25.94	28.25	23.23
Hemodialysis procedure with single physician evaluation	90935	68.04	67.48	67.97	71.74	74.94	68.11
Dialysis procedure other than hem	90945	80.19	79.76	80.47	85.35	89.81	80.31
Electrocardiogram	93000	16.61	16.56	16.83	18.53	19.98	16.67
Tracing EKG (no interpretation or report)	93005	8.80	8.82	9.04	10.29	11.37	8.85
Cardiovascular stress test	93015	72.26	72.60	73.71	79.85	86.30	72.51
Right heart catheter (includes oxygen saturation & cardiac output measurements)	93451	719.09	721.49	736.63	823.51	903.32	722.42
New patient visit	99201	24.44	24.15	24.38	26.17	27.47	24.47
Established patient visit	99211	8.45	8.38	8.44	8.93	9.33	8.45
Observation care discharge fee	99217	66.83	66.35	66.97	71.40	75.15	66.93
Initial observation care	99218	92.00	91.16	91.90	97.58	102.15	92.10
Initial hospital care	99221	94.15	92.72	93.58	100.77	105.42	94.23
Subsequent observation care	99224	36.84	36.38	36.70	39.26	41.08	36.88
Subsequent hospital care	99231	36.29	35.92	36.22	38.50	40.29	36.32
Observation/hospital same date	99234	124.62	122.91	124.01	133.07	139.22	124.73
Hospital discharge fee	99238	66.87	66.49	67.10	71.32	75.10	66.97

Table 4 - Medicare Non-Facility Fee-for-Service Billing Amounts

Description	Code	MS	AL	TN	WY	CT	KY
Drainage of skin abscess	10060	107.37	107.07	108.72	119.01	127.99	107.70
Drainage of hematoma, seroma	10140	150.57	149.88	152.33	167.96	180.90	151.04
Complex drainage wound, postoperative infection	10180	227.98	225.20	229.17	256.94	276.29	228.63
Removal of breast lesion	19120	456.82	447.71	454.94	511.41	544.66	457.73
Masectomy, partial	19301	605.98	587.83	596.17	672.33	706.87	606.51
Removal of hip prosthesis	27090	771.40	753.40	764.47	856.82	906.45	772.51
Removal of hip prosthesis, complicated	27091	1,489.57	1,450.14	1,470.54	1,649.72	1,738.12	1,491.20
Hemiarthroplasty (partial hip replacement)	27125	1,054.72	1,028.29	1,043.08	1,169.85	1,234.94	1,056.05
Arthroplasty (revised kneecap with implant)	27438	782.48	764.13	775.35	869.05	919.26	783.60
Aspiration of plural space without imaging - Thoracentesis	32554	498.26	502.59	512.85	567.83	624.19	500.71
Aspiration of plural space with imaging - Thoracentesis	32555	575.23	579.81	591.55	655.06	719.43	578.01
Insert/replace permanent pacemaker	33208	488.34	471.54	477.98	540.88	565.98	488.56
Endoscopy ligate perf veins	37500	620.71	597.19	605.16	687.02	716.49	620.81
Remove tonsils and adenoids	42820	276.04	272.51	276.14	302.92	321.49	276.56
Esophagus endoscopy	43215	146.22	142.87	144.64	160.10	168.24	146.36
Colonoscopy, flexible	45378	370.34	367.76	374.05	415.33	447.54	371.49
Vaginal delivery	59400	1,977.03	1,898.55	1,928.52	2,221.62	2,331.17	1,978.04
Antepartum care (4 to 6 visits)	59425	429.15	414.51	421.32	483.31	510.10	429.60
Antepartum care (7 or more visits)	59426	767.59	742.49	754.67	863.89	912.58	768.46
Care after delivery	59430	173.87	168.33	171.12	195.84	207.11	174.08
Cesarean delivery	59510	2,184.87	2,095.59	2,128.90	2,457.65	2,577.56	2,185.86
Biopsy of thyroid with percutaneous needle	60100	103.77	102.85	104.20	113.54	120.74	103.99
Partial removal of thyroid, unilateral lobectomy	60220	665.77	650.08	658.74	733.26	772.36	666.54
Laparoscopy, with adrenalectomy, exploration of adrenal gland	60650	1,111.50	1,079.27	1,092.65	1,219.43	1,275.91	1,112.14
Injection, epidural blood or clot patch	62273	163.77	163.00	165.31	180.21	192.83	164.21
Drain outer ear canal lesion	69020	219.58	219.88	223.96	247.91	269.80	220.46
Contrast x-ray of brain	70010	58.85	56.88	57.54	64.35	66.94	58.86
X-ray exam of neck	70360	25.45	25.52	26.00	28.74	31.31	25.56
Mammogram screening	77057	73.73	73.91	75.12	82.05	88.80	73.99
Cytopathology	88141	29.21	29.11	29.49	31.88	34.02	29.28
Tissue exam by pathologist	88304	39.53	39.77	40.53	44.73	48.91	39.71
Tissue exam by pathologist, level 4 surgical pathology	88305	64.04	64.37	65.29	70.25	75.69	64.26
Histochemical stains, special stains	88314	72.10	72.69	74.02	81.13	88.65	72.42
Immunization administration	90471	23.13	23.27	23.68	25.94	28.25	23.23
Hemodialysis procedure with single physician evaluation	90935	68.04	67.48	67.97	71.74	74.94	68.11
Dialysis procedure other than hem	90945	80.19	79.76	80.47	85.35	89.81	80.31
Electrocardiogram	93000	16.61	16.56	16.83	18.53	19.98	16.67
Tracing EKG (no interpretation or report)	93005	8.80	8.82	9.04	10.29	11.37	8.85
Cardiovascular stress test	93015	72.26	72.60	73.71	79.85	86.30	72.51
Right heart catheter (includes oxygen saturation & cardiac output measurements)	93451	719.09	721.49	736.63	823.51	903.32	722.42
New patient visit	99201	40.05	39.98	40.57	44.21	47.48	40.17
Established patient visit	99211	18.46	18.53	18.83	20.49	22.18	18.53
Observation care discharge fee	99217	66.83	66.35	66.97	71.40	75.15	66.93
Initial observation care	99218	92.00	91.16	91.90	97.58	102.15	92.10
Initial hospital care	99221	94.15	92.72	93.58	100.77	105.42	94.23
Subsequent observation care	99224	36.84	36.38	36.70	39.26	41.08	36.88
Subsequent hospital care	99231	36.29	35.92	36.22	38.50	40.29	36.32
Observation/hospital same date	99234	124.62	122.91	124.01	133.07	139.22	124.73
Hospital discharge fee	99238	66.87	66.49	67.10	71.32	75.10	66.97

Table 6 - Facility Rate Comparison Factor

Description	Code	MS	AL	TN	WY	CT	KY
Drainage of skin abscess	10060	1.00	1.01	0.99	0.91	0.85	1.00
Drainage of hematoma, seroma	10140	1.00	1.01	1.00	0.91	0.85	1.00
Complex drainage wound, postoperative infection	10180	1.00	1.02	1.01	0.90	0.84	1.00
Removal of breast lesion	19120	1.00	1.03	1.01	0.90	0.85	1.00
Masectomy, partial	19301	1.00	1.03	1.02	0.90	0.86	1.00
Removal of hip prosthesis	27090	1.00	1.02	1.01	0.90	0.85	1.00
Removal of hip prosthesis, complicated	27091	1.00	1.03	1.01	0.90	0.86	1.00
Hemiarthroplasty (partial hip replacement)	27125	1.00	1.03	1.01	0.90	0.85	1.00
Arthroplasty (revised kneecap with implant)	27438	1.00	1.02	1.01	0.90	0.85	1.00
Aspiration of plural space without imaging - Thoracentesis	32554	1.00	1.02	1.01	0.94	0.90	1.00
Aspiration of plural space with imaging - Thoracentesis	32555	1.00	1.02	1.01	0.94	0.90	1.00
Insert/replace permanent pacemaker	33208	1.00	1.04	1.02	0.90	0.86	1.00
Endoscopy ligate perf veins	37500	1.00	1.04	1.03	0.90	0.87	1.00
Remove tonsils and adenoids	42820	1.00	1.01	1.00	0.91	0.86	1.00
Esophagus endoscopy	43215	1.00	1.02	1.01	0.91	0.87	1.00
Colonoscopy, flexible	45378	1.00	1.02	1.01	0.91	0.87	1.00
Vaginal delivery	59400	1.00	1.04	1.03	0.89	0.85	1.00
Antepartum care (4 to 6 visits)	59425	1.00	1.05	1.03	0.89	0.86	1.00
Antepartum care (7 or more visits)	59426	1.00	1.05	1.03	0.90	0.86	1.00
Care after delivery	59430	1.00	1.05	1.03	0.89	0.86	1.00
Cesarean delivery	59510	1.00	1.04	1.03	0.89	0.85	1.00
Biopsy of thyroid with percutaneous needle	60100	1.00	1.02	1.01	0.93	0.90	1.00
Partial removal of thyroid, unilateral lobectomy	60220	1.00	1.02	1.01	0.91	0.86	1.00
Laparoscopy, with adrenalectomy, exploration of adrenal gland	60650	1.00	1.03	1.02	0.91	0.87	1.00
Injection, epidural blood or clot patch	62273	1.00	1.01	1.00	0.93	0.89	1.00
Drain outer ear canal lesion	69020	1.00	1.01	0.99	0.90	0.84	1.00
Contrast x-ray of brain	70010	1.00	1.03	1.02	0.91	0.88	1.00
X-ray exam of neck	70360	1.00	1.00	0.98	0.89	0.81	1.00
Mammogram screening	77057	1.00	1.00	0.98	0.90	0.83	1.00
Cytopathology	88141	1.00	1.00	0.99	0.92	0.86	1.00
Tissue exam by pathologist	88304	1.00	0.99	0.98	0.88	0.81	1.00
Tissue exam by pathologist, level 4 surgical pathology	88305	1.00	0.99	0.98	0.91	0.85	1.00
Histochemical stains, special stains	88314	1.00	0.99	0.97	0.89	0.81	1.00
Immunization administration	90471	1.00	0.99	0.98	0.89	0.82	1.00
Hemodialysis procedure with single physician evaluation	90935	1.00	1.01	1.00	0.95	0.91	1.00
Dialysis procedure other than hem	90945	1.00	1.01	1.00	0.94	0.89	1.00
Electrocardiogram	93000	1.00	1.00	0.99	0.90	0.83	1.00
Tracing EKG (no interpretation or report)	93005	1.00	1.00	0.97	0.86	0.77	0.99
Cardiovascular stress test	93015	1.00	1.00	0.98	0.90	0.84	1.00
Right heart catheter (includes oxygen saturation & cardiac output measurements)	93451	1.00	1.00	0.98	0.87	0.80	1.00
New patient visit	99201	1.00	1.01	1.00	0.93	0.89	1.00
Established patient visit	99211	1.00	1.01	1.00	0.95	0.91	1.00
Observation care discharge fee	99217	1.00	1.01	1.00	0.94	0.89	1.00
Initial observation care	99218	1.00	1.01	1.00	0.94	0.90	1.00
Initial hospital care	99221	1.00	1.02	1.01	0.93	0.89	1.00
Subsequent observation care	99224	1.00	1.01	1.00	0.94	0.90	1.00
Subsequent hospital care	99231	1.00	1.01	1.00	0.94	0.90	1.00
Observation/hospital same date	99234	1.00	1.01	1.00	0.94	0.90	1.00
Hospital discharge fee	99238	1.00	1.01	1.00	0.94	0.89	1.00

Table 7 - Non- Facility Rate Comparison Factor

Description	Code	MS	AL	TN	WY	CT	KY
Drainage of skin abscess	10060	1.00	1.00	0.99	0.91	0.85	1.00
Drainage of hematoma, seroma	10140	1.00	1.00	0.99	0.91	0.85	1.00
Complex drainage wound, postoperative infection	10180	1.00	1.01	0.99	0.90	0.84	1.00
Removal of breast lesion	19120	1.00	1.02	1.00	0.90	0.85	1.00
Masectomy, partial	19301	1.00	1.03	1.02	0.90	0.86	1.00
Removal of hip prosthesis	27090	1.00	1.02	1.01	0.90	0.85	1.00
Removal of hip prosthesis, complicated	27091	1.00	1.03	1.01	0.90	0.86	1.00
Hemiarthroplasty (partial hip replacement)	27125	1.00	1.03	1.01	0.90	0.85	1.00
Arthroplasty (revised kneecap with implant)	27438	1.00	1.02	1.01	0.90	0.85	1.00
Aspiration of plural space without imaging - Thoracentesis	32554	1.00	0.99	0.97	0.94	0.90	1.00
Aspiration of plural space with imaging - Thoracentesis	32555	1.00	0.99	0.97	0.94	0.90	1.00
Insert/replace permanent pacemaker	33208	1.00	1.04	1.02	0.90	0.86	1.00
Endoscopy ligate perf veins	37500	1.00	1.04	1.03	0.90	0.87	1.00
Remove tonsils and adenoids	42820	1.00	1.01	1.00	0.91	0.86	1.00
Esophagus endoscopy	43215	1.00	1.02	1.01	0.91	0.87	1.00
Colonoscopy, flexible	45378	1.00	1.01	0.99	0.91	0.87	1.00
Vaginal delivery	59400	1.00	1.04	1.03	0.89	0.85	1.00
Antepartum care (4 to 6 visits)	59425	1.00	1.04	1.02	0.89	0.86	1.00
Antepartum care (7 or more visits)	59426	1.00	1.03	1.02	0.90	0.86	1.00
Care after delivery	59430	1.00	1.03	1.02	0.89	0.86	1.00
Cesarean delivery	59510	1.00	1.04	1.03	0.89	0.85	1.00
Biopsy of thyroid with percutaneous needle	60100	1.00	1.01	1.00	0.93	0.90	1.00
Partial removal of thyroid, unilateral lobectomy	60220	1.00	1.02	1.01	0.91	0.86	1.00
Laparoscopy, with adrenalectomy, exploration of adrenal gland	60650	1.00	1.03	1.02	0.91	0.87	1.00
Injection, epidural blood or clot patch	62273	1.00	1.00	0.99	0.93	0.89	1.00
Drain outer ear canal lesion	69020	1.00	1.00	0.98	0.90	0.84	1.00
Contrast x-ray of brain	70010	1.00	1.03	1.02	0.91	0.88	1.00
X-ray exam of neck	70360	1.00	1.00	0.98	0.89	0.81	1.00
Mammogram screening	77057	1.00	1.00	0.98	0.90	0.83	1.00
Cytopathology	88141	1.00	1.00	0.99	0.92	0.86	1.00
Tissue exam by pathologist	88304	1.00	0.99	0.98	0.88	0.81	1.00
Tissue exam by pathologist, level 4 surgical pathology	88305	1.00	0.99	0.98	0.91	0.85	1.00
Histochemical stains, special stains	88314	1.00	0.99	0.97	0.89	0.81	1.00
Immunization administration	90471	1.00	0.99	0.98	0.89	0.82	1.00
Hemodialysis procedure with single physician evaluation	90935	1.00	1.01	1.00	0.95	0.91	1.00
Dialysis procedure other than hem	90945	1.00	1.01	1.00	0.94	0.89	1.00
Electrocardiogram	93000	1.00	1.00	0.99	0.90	0.83	1.00
Tracing EKG (no interpretation or report)	93005	1.00	1.00	0.97	0.86	0.77	0.99
Cardiovascular stress test	93015	1.00	1.00	0.98	0.90	0.84	1.00
Right heart catheter (includes oxygen saturation & cardiac output measurements)	93451	1.00	1.00	0.98	0.87	0.80	1.00
New patient visit	99201	1.00	1.00	0.99	0.93	0.89	1.00
Established patient visit	99211	1.00	1.00	0.98	0.95	0.91	1.00
Observation care discharge fee	99217	1.00	1.01	1.00	0.94	0.89	1.00
Initial observation care	99218	1.00	1.01	1.00	0.94	0.90	1.00
Initial hospital care	99221	1.00	1.02	1.01	0.93	0.89	1.00
Subsequent observation care	99224	1.00	1.01	1.00	0.94	0.90	1.00
Subsequent hospital care	99231	1.00	1.01	1.00	0.94	0.90	1.00
Observation/hospital same date	99234	1.00	1.01	1.00	0.94	0.90	1.00
Hospital discharge fee	99238	1.00	1.01	1.00	0.94	0.89	1.00

Table 8 - Rate Factor Differences Between Facility and Non-Facility Rates

Description	Code	MS	AL	TN	WY	CT	KY
Drainage of skin abscess	10060	0.00	0.00	0.00	0.00	0.00	0.00
Drainage of hematoma, seroma	10140	0.00	0.01	0.01	0.00	0.00	0.00
Complex drainage wound, postoperative infection	10180	0.00	0.01	0.01	0.00	0.00	0.00
Removal of breast lesion	19120	0.00	0.01	0.01	0.00	0.00	0.00
Masectomy, partial	19301	0.00	0.00	0.00	0.00	0.00	0.00
Removal of hip prosthesis	27090	0.00	0.00	0.00	0.00	0.00	0.00
Removal of hip prosthesis, complicated	27091	0.00	0.00	0.00	0.00	0.00	0.00
Hemiarthroplasty (partial hip replacement)	27125	0.00	0.00	0.00	0.00	0.00	0.00
Arthroplasty (revised kneecap with implant)	27438	0.00	0.00	0.00	0.00	0.00	0.00
Aspiration of plural space without imaging - Thoracentesis	32554	0.00	0.03	0.04	0.00	0.00	0.00
Aspiration of plural space with imaging - Thoracentesis	32555	0.00	0.03	0.04	0.00	0.00	0.00
Insert/replace permanent pacemaker	33208	0.00	0.00	0.00	0.00	0.00	0.00
Endoscopy ligate perf veins	37500	0.00	0.00	0.00	0.00	0.00	0.00
Remove tonsils and adenoids	42820	0.00	0.00	0.00	0.00	0.00	0.00
Esophagus endoscopy	43215	0.00	0.00	0.00	0.00	0.00	0.00
Colonoscopy, flexible	45378	0.00	0.02	0.02	0.00	0.00	0.00
Vaginal delivery	59400	0.00	0.00	0.00	0.00	0.00	0.00
Antepartum care (4 to 6 visits)	59425	0.00	0.01	0.02	0.00	0.00	0.00
Antepartum care (7 or more visits)	59426	0.00	0.01	0.02	0.00	0.00	0.00
Care after delivery	59430	0.00	0.02	0.02	0.00	0.00	0.00
Cesarean delivery	59510	0.00	0.00	0.00	0.00	0.00	0.00
Biopsy of thyroid with percutaneous needle	60100	0.00	0.01	0.01	0.00	0.00	0.00
Partial removal of thyroid, unilateral lobectomy	60220	0.00	0.00	0.00	0.00	0.00	0.00
Laparoscopy, with adrenalectomy, exploration of adrenal gland	60650	0.00	0.00	0.00	0.00	0.00	0.00
Injection, epidural blood or clot patch	62273	0.00	0.01	0.01	0.00	0.00	0.00
Drain outer ear canal lesion	69020	0.00	0.01	0.01	0.00	0.00	0.00
Contrast x-ray of brain	70010	0.00	0.00	0.00	0.00	0.00	0.00
X-ray exam of neck	70360	0.00	0.00	0.00	0.00	0.00	0.00
Mammogram screening	77057	0.00	0.00	0.00	0.00	0.00	0.00
Cytopathology	88141	0.00	0.00	0.00	0.00	0.00	0.00
Tissue exam by pathologist	88304	0.00	0.00	0.00	0.00	0.00	0.00
Tissue exam by pathologist, level 4 surgical pathology	88305	0.00	0.00	0.00	0.00	0.00	0.00
Histochemical stains, special stains	88314	0.00	0.00	0.00	0.00	0.00	0.00
Immunization administration	90471	0.00	0.00	0.00	0.00	0.00	0.00
Hemodialysis procedure with single physician evaluation	90935	0.00	0.00	0.00	0.00	0.00	0.00
Dialysis procedure other than hem	90945	0.00	0.00	0.00	0.00	0.00	0.00
Electrocardiogram	93000	0.00	0.00	0.00	0.00	0.00	0.00
Tracing EKG (no interpretation or report)	93005	0.00	0.00	0.00	0.00	0.00	0.00
Cardiovascular stress test	93015	0.00	0.00	0.00	0.00	0.00	0.00
Right heart catheter (includes oxygen saturation & cardiac output measurements)	93451	0.00	0.00	0.00	0.00	0.00	0.00
New patient visit	99201	0.00	0.01	0.02	0.00	0.00	0.00
Established patient visit	99211	0.00	0.01	0.02	0.00	0.00	0.00
Observation care discharge fee	99217	0.00	0.00	0.00	0.00	0.00	0.00
Initial observation care	99218	0.00	0.00	0.00	0.00	0.00	0.00
Initial hospital care	99221	0.00	0.00	0.00	0.00	0.00	0.00
Subsequent observation care	99224	0.00	0.00	0.00	0.00	0.00	0.00
Subsequent hospital care	99231	0.00	0.00	0.00	0.00	0.00	0.00
Observation/hospital same date	99234	0.00	0.00	0.00	0.00	0.00	0.00
Hospital discharge fee	99238	0.00	0.00	0.00	0.00	0.00	0.00

Table 10 – Medicare Fee-for-Service Price Compared to Private Health Insurance Price in MS

Code Description	Code	Blue Cross Blue Shield of Mississippi	Medicare - Facility	Medicare - Non-Facility	% of BCBS reimbursement to Medicare - Facility	% of BCBS reimbursement to Medicare - Non-Facility
Drainage of skin abscess	10060	170.00	89.69	107.37	189.54%	158.33%
Drainage of hematoma, seroma	10140	195.00	110.50	150.57	176.47%	129.51%
Complex drainage wound, postoperative infection	10180	262.00	166.40	227.98	157.45%	114.92%
Removal of breast lesion	19120	701.00	383.46	456.82	182.81%	153.45%
Masectomy, partial	19301	680.00	605.98	605.98	112.21%	112.21%
Removal of hip prosthesis	27090	1,473.00	771.40	771.40	190.95%	190.95%
Removal of hip prosthesis, complicated	27091	3,126.00	1,489.57	1,489.57	209.86%	209.86%
Hemiarthroplasty (partial hip replacement)	27125	2,177.00	1,054.72	1,054.72	206.41%	206.41%
Arthroplasty (revised kneecap with implant)	27438	1,643.00	782.48	782.48	209.97%	209.97%
Aspiration of plural space without imaging - Thoracentesis	32554	2,213.00	85.47	498.26	2589.21%	444.15%
Aspiration of plural space with imaging - Thoracentesis	32555	2,549.00	106.76	575.23	2387.60%	443.13%
Insert/replace permanent pacemaker	33208	1,211.00	488.34	488.34	247.98%	247.98%
Endoscopy ligate perf veins	37500	1,314.00	620.71	620.71	211.69%	211.69%
Remove tonsils and adenoids	42820	659.00	276.04	276.04	238.73%	238.73%
Esophagus endoscopy	43215	358.00	146.22	146.22	244.84%	244.84%
Colonoscopy, flexible	45378	812.00	205.64	370.34	394.86%	219.26%
Vaginal delivery	59400	2,875.00	1,977.03	1,977.03	145.42%	145.42%
Antepartum care (4 to 6 visits)	59425	631.00	339.29	429.15	185.98%	147.03%
Antepartum care (7 or more visits)	59426	1,108.00	598.47	767.59	185.14%	144.35%
Care after delivery	59430	218.00	132.62	173.87	164.38%	125.38%
Cesarean delivery	59510	2,899.00	2,184.87	2,184.87	132.69%	132.69%
Biopsy of thyroid with percutaneous needle	60100	257.00	74.31	103.77	345.85%	247.66%
Partial removal of thyroid, unilateral lobectomy	60220	1,549.00	665.77	665.77	232.66%	232.66%
Laparoscopy, with adrenalectomy, exploration of adrenal gland	60650	2,344.00	1,111.50	1,111.50	210.89%	210.89%
Injection, epidural blood or clot patch	62273	333.00	108.68	163.77	306.40%	203.33%
Drain outer ear canal lesion	69020	293.00	134.72	219.58	217.49%	133.44%
Contrast x-ray of brain	70010	265.00	58.85	58.85	450.30%	450.30%
X-ray exam of neck	70360	40.00	25.45	25.45	157.17%	157.17%
Mammogram screening	77057	105.74	73.73	73.73	143.42%	143.42%
Cytopathology	88141	53.00	29.21	29.21	181.44%	181.44%
Tissue exam by pathologist	88304	no such code	39.53	39.53		
Tissue exam by pathologist, level 4 surgical pathology	88305	no such code	64.04	64.04		
Histochemical stains, special stains	88314	116.00	72.10	72.10	160.89%	160.89%
Immunization administration	90471	30.00	23.13	23.13	129.70%	129.70%
Hemodialysis procedure with single physician evaluation	90935	144.00	68.04	68.04	211.64%	211.64%
Dialysis procedure other than hem	90945	120.00	80.19	80.19	149.64%	149.64%
Electrocardiogram	93000	30.00	16.61	16.61	180.61%	180.61%
Tracing EKG (no interpretation or report)	93005	20.00	8.80	8.80	227.27%	227.27%
Cardiovascular stress test	93015	154.00	72.26	72.26	213.12%	213.12%
Right heart catheter (includes oxygen saturation and cardiac output measurements)	93451	1,078.00	719.09	719.09	149.91%	149.91%
New patient visit	99201	45.00	24.44	40.05	184.12%	112.36%
Established patient visit	99211	26.00	8.45	18.46	307.69%	140.85%
Observation care discharge fee	99217	94.00	66.83	66.83	140.66%	140.66%
Initial observation care	99218	98.00	92.00	92.00	106.52%	106.52%
Initial hospital care	99221	103.00	94.15	94.15	109.40%	109.40%
Subsequent observation care	99224	40.00	36.84	36.84	108.58%	108.58%
Subsequent hospital care	99231	46.00	36.29	36.29	126.76%	126.76%
Observation/hospital same date	99234	155.00	124.62	124.62	124.38%	124.38%
Hospital discharge fee	99238	81.00	66.87	66.87	121.13%	121.13%

Table 11 – MS Medicaid Prices Compared to BCBS and Medicare[xl]

Code Description	Code	Medicaid Price	Medicare - Facility	Medicaid as Percentage of Medicare Facility
Drainage of skin abscess	10060	45.91	89.69	51.19%
Drainage of hematoma, seroma	10140	78.97	110.50	71.47%
Complex drainage wound, postoperative infection	10180	147.18	166.40	88.45%
Removal of breast lesion	19120	337.03	383.46	87.89%
Masectomy, partial	19301	533.67	605.98	88.07%
Removal of hip prosthesis	27090	687.13	771.40	89.08%
Removal of hip prosthesis, complicated	27091	1,332.70	1,489.57	89.47%
Hemiarthroplasty (partial hip replacement)	27125	940.91	1,054.72	89.21%
Arthroplasty (revised kneecap with implant)	27438	696.57	782.48	89.02%
Aspiration of plural space without imaging - Thoracentesis	32554	76.92	85.47	90.00%
Aspiration of plural space with imaging - Thoracentesis	32555	96.08	106.76	90.00%
Insert/replace permanent pacemaker	33208	447.92	488.34	91.72%
Endoscopy ligate perf veins	37500	602.13	620.71	97.01%
Remove tonsils and adenoids	42820	248.27	276.04	89.94%
Esophagus endoscopy	43215	132.18	146.22	90.40%
Colonoscopy, flexible	45378	185.16	205.64	90.04%
Vaginal delivery	59400	no such code	1,977.03	
Antepartum care (4 to 6 visits)	59425	95.47	339.29	28.14%
Antepartum care (7 or more visits)	59426	97.56	598.47	16.30%
Care after delivery	59430	119.67	132.62	90.24%
Cesarean delivery	59510	no such code	2,184.87	
Biopsy of thyroid with percutaneous needle	60100	41.94	74.31	56.44%
Partial removal of thyroid, unilateral lobectomy	60220	597.33	665.77	89.72%
Laparoscopy, with adrenalectomy, exploration of adrenal gland	60650	1,001.31	1,111.50	90.09%
Injection, epidural blood or clot patch	62273	96.53	108.68	88.82%
Drain outer ear canal lesion	69020	45.91	134.72	34.08%
Contrast x-ray of brain	70010	77.93	58.85	132.42%
X-ray exam of neck	70360	15.09	25.45	59.29%
Mammogram screening	77057	36.58	73.73	49.61%
Cytopathology	88141	24.44	29.21	83.67%
Tissue exam by pathologist	88304	39.76	39.53	100.58%
Tissue exam by pathologist, level 4 surgical pathology	88305	54.35	64.04	84.87%
Histochemical stains, special stains	88314	45.33	72.10	62.87%
Immunization administration	90471	19.50	23.13	84.31%
Hemodialysis procedure with single physician evaluation	90935	62.59	68.04	91.99%
Dialysis procedure other than hem	90945	71.15	80.19	88.73%
Electrocardiogram	93000	15.49	16.61	93.26%
Tracing EKG (no interpretation or report)	93005	8.19	8.80	93.07%
Cardiovascular stress test	93015	71.96	72.26	99.58%
Right heart catheter (includes oxygen saturation and cardiac output measurements)	93451	510.59	719.09	71.01%
New patient visit	99201	22.01	24.44	90.06%
Established patient visit	99211	7.87	8.45	93.14%
Observation care discharge fee	99217	59.64	66.83	89.24%
Initial observation care	99218	80.98	92.00	88.02%
Initial hospital care	99221	83.97	94.15	89.19%
Subsequent observation care	99224	no such code	36.84	
Subsequent hospital care	99231	32.67	36.29	90.02%
Observation/hospital same date	99234	112.20	124.62	90.03%
Hospital discharge fee	99238	59.41	66.87	88.84%

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